THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013010

STATE FILE NUMBER

Dr Owner

FILED MAY 11 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 417C

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Inside Limits: Yes Y No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Johns — Length of stay in Hospital: 10 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ark. b. COUNTY: Marion
c. CITY OR TOWN: Duggansville 80.30 — Inside Limits: Yes No Y
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes Y No

3. NAME OF DECEASED (Type or print): First: Lige Middle: Last: Tabor
4. DATE OF DEATH: Month: APRIL Day: 22 Year: 59
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED X NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH: 12-6-1881
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (City and state or country): Marion Co. Ark.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Jim Tabor
14. MOTHER'S MAIDEN NAME: Lizzie Kyle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 431-10-8849
17. INFORMANT: Hobart Tabor Address: Duggansville Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
Post traumatic
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Skull Fracture 9135
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 44
19. WAS AUTOPSY PERFORMED? YES NO X 2

20a. ACCIDENT ✓ SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY occurred. (Enter nature of injury in Part I or Part II of item 18.): Fall
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: 4-11-59
903
20d. INJURY OCCURRED WHILE AT WORK ✓ NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory (street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION: Duggansville COUNTY STATE: Mo.

21. I attended the deceased from 4-12-59 to 4-22-59 and last saw her/him alive on 4-21-59
Death occurred at 4:10 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lucil R. Cannon MD
22b. ADDRESS: Springfield, Mo 404 Prof. Bldg.
22c. DATE SIGNED: 4-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-22-59
23c. NAME OF CEMETERY OR CREMATORY: Hart
23d. LOCATION (City, town, or county) (State): Duggansville Mo.

24. FUNERAL DIRECTOR: Chinkingbeard ADDRESS: Seminole
25. DATE RECD. BY LOCAL REG.: 5-4-59
26. REGISTRAR'S SIGNATURE: Effie E. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John R. Usrey.....

Licensed Embalmer No. 48

P. O. Address Cameron

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.